



THE VIRGIN ISLANDS OF THE UNITED STATES
CIVIL RIGHTS COMMISSION
DISCRIMINATION COMPLAINT FORM

OFFICE OF THE GOVERNOR

Complainant: _____

Mailing Address: _____

City, State, and Zip Code: _____

Telephone Number: _____

(Area Code)

(Home)

(Area Code)

(Business)

Alleged Discriminator: _____

Address: _____

City, State, and Zip Code: _____

Telephone Number: _____

(Area Code)

Institution which you believe has discriminated against you:

Name: _____

Address: _____

City, State, and Zip Code: _____

Telephone Number: _____

(Area Code)

Injured party was discriminated against because of (check one or more):

_____ Race or Color

_____ Sex

_____ National Origin

_____ Handicap

_____ Age

Other (Explain)

When did the discrimination occur? _____
(Date)

Describe the discrimination:

Have efforts been made to resolve this complaint through the institution's internal grievance procedure? Yes____ No ____If "yes", what is the status of the grievance?

Has this complaint been filed with any other Federal, State, or Local Civil Rights or Court: Agency or court? Yes___ No___ If "yes" What Agency or Court name:

Contact person:_____

Address: _____

City, State, and Zip Code:_____

Telephone Number: _____ Date Filed _____

Do you intend to file with another agency or court: Yes ___ No _____ Agency or Court

name:_____

Address:_____

City, State, and Zip Code:_____

Telephone Number:_____

(area code)

Date when you intend to file:_____

Have you filed any other complaints with this agency: Yes ____ No ____

Against whom were they filed:

Name:_____

Address:_____

City, State, and Zip Code: _____

Telephone Number: _____

Date of filing: _____

Briefly, what was the complaint about?

What was the results:

Signature:_____

Date:_____

VERIFIED BY COMPLAINANT: _____

THIS IS TO CONFIRM THAT THE ABOVE STATEMENT IS TRUE.

